INDIANA PATIENT'S COMPENSATION FUND

FREQUENTLY ASKED QUESTIONS

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Ancillary/Independent Ancillary Providers

Q: What are the class codes/surcharge calculations for healthcare providers that are not licensed as physicians, nursing homes or hospitals?

A: Healthcare providers who are **not** licensed as physicians, nursing homes or hospitals are assessed surcharge at the rate of 110% of underlying professional liability premium or a minimum surcharge of $100, whichever is greater. This rate applies to all healthcare providers, including non-physicians. Members of corporations or partnerships and Independent Ancillary Providers (defined under IAC 760 1-21) MUST establish financial responsibility separately from such entities in accordance with Indiana Code IC 34-18-4-4

80116	PHYSICIANS OR SURGEONS ASSISTANT
80210	DENTISTS - ENGAGED IN ORAL SURGERY
80211	DENTISTS - N.O.C.
80410	CHIROPRACTORS
80616	NURSE PRACTITIONER
80750	OCCUPATIONAL THERAPIST
80912	PSYCHOLOGIST
80969	INHALATION/RESPIRATORY THERAPIST
80938	PHYSICAL THERAPISTS
80960	NURSE ANESTHETISTS
80962	NURSE MIDWIFE
80993	PODIATRISTS
80994	OPTOMETRISTS
80998	NURSE
80999	CORPORATE LIABILITY
90001	EMERGENCY MEDICAL TECHNICIAN

Q: Rule 21 defines an Independent Ancillary Provider as a state-licensed health care provider who does not require direct supervision or direction in providing health care. Because Rule 21 specifies that CRNAs are to be considered Independent Ancillary Providers, does this mean a CRNA can practice without direct supervision?

A: No. Rule 21 was not intended to expand the scope of any provider's practice. The Department of Insurance cannot authorize anyone to practice medicine in any capacity. For official guidance on the authorized scope of a CRNA's practice, please see IC 25-22.5-1-2(13), IC 16-18-2-14, and 410 IAC 15-2.5-4, prohibiting CRNAs from administering anesthesia except under the direction of and in the immediate presence of a physician.

Q: Are independent ancillary providers required to obtain separate limits per IAC 760 1-21-10 (c) if employed by a hospital or nursing home?

A: No. An independent ancillary provider only requires separate limits if he or she is employed by an entity other than a hospital, nursing home. Additionally, institutions of higher education may include optometrists and/or dentists acting within the scope of their employment as faculty members.

Q: Where can I find the current percentage charged for providers who are not licensed as a physician, nursing home or hospital?

A: All other provider surcharges are found at 760 IAC 1-21-8.

Q: Can the credits per Rule 60 be applied on non-physician surcharges?

A: No. Non-physician surcharges are calculated on a percentage of premiums; therefore, any discounts given on the underlying coverage would already be accounted for when calculating the surcharge amount.

Reporting Endorsement/Tail Coverage

Q: What surcharge and rating methodology will apply to reporting endorsements (tail policies) for providers not licensed as a physician, nursing home or hospital?

A: The amount of surcharge is based on 110% of the underlying professional liability premium charged by the insurance carrier for the tail policy or a minimum surcharge of $100, whichever is greater.

Q: Does the PCF prohibit companies from offering limited tail?

A: PCF does not prohibit limited tail, but the company must file the reporting endorsement reflecting the date for which prior acts coverage is to begin through the date that reporting endorsement will expire. The company must notify the PCF thirty days prior to expiration of the reporting endorsement, by filing the certificate of insurance indicating the effective date of expiration. If the company fails to notify the Department in the above manner, the PCF will hold the company liable for any claims filed after the expiration date of the reporting endorsement, per IC 34-18-13-4.

Q: What surcharge and rating methodology will apply to reporting endorsements (tail policies) for hospitals and physicians falling under Rule 60?

A: Please refer to Bulletin 162.

Q: What surcharge and rating methodology will apply to reporting endorsements (tail policies) for nursing homes?

A: Please refer to Bulletin 162

Q: Does a reporting endorsement need to be submitted to the PCF for a physician who shares in the limits of the hospital under a claims-made policy and leaves or his/her employment is terminated?

A: No. The provider would continue to be covered under the PCF as long as the hospital continues to pay surcharge as a qualified provider. Please note that the Department does not currently track employed physicians; therefore, when a complaint is initially filed the Department would determine the physician as not qualified until a signed statement from the risk manager of the hospital is submitted stating that physician was an employee at time of occurrence and appropriate amount of surcharge was paid to include the physician under the hospital coverage.

Q: Does a reporting endorsement need to be filed for a physician going from individual limits to shared limits of a hospital?

A: Yes. A physician who does not purchase tail coverage for the individual policy will not be considered qualified for any claims filed after the expiration date of coverage.

Q: What is the amount of surcharge assessed for locum tenen reporting endorsements?

A: A minimum surcharge of $100 is required to be paid for each reporting endorsement issued.

Q: What happens if a locum tenen physician moves to another carrier which elects to pick up prior acts?

A: A reporting endorsement from the new carrier is required reflecting the beginning date of the first assignment and the ending date of the last assignment with the previous carrier, with the understanding that the new reporting endorsement will only cover the dates reflected on each assignment certificate. The reporting endorsement filed by the new carrier will cancel out all previous endorsements under the previous carrier name. The $100 minimum surcharge will need to be remitted.

Hospitals

Q: May a hospital provide coverage to physicians and surgeons on a shared basis?

Hospitals may cover **employed** physicians within the limits of the hospital's liability, for exposures arising from such employment. Such hospitals must have this exposure calculated into the hospital's surcharge, by use of the employed physician rate, as set out in the Department's hospital worksheet. PLEASE REMEMBER that coverage only applies to physicians acting within the scope of their employment.

Q: Can the credits available for health care providers identified under Rule 60 be taken for physicians sharing in the limits of a hospital?

A: Effective January 1, 2007, there is no longer a hospital credit for employed physicians; therefore, the credits available per Rule 60 may be applied to the annual surcharges for physicians identified under Rule 60. Please note that only one credit can be applied for each physician.

Q: What are the discounts for hospitals with risk management programs?

A: There is NO discount for hospital risk management programs. Hospitals **without** a risk management or quality assurance program will be penalized.

Q: What defines an acceptable risk management program?

A: Any program meeting the licensing requirements of the State Department of Health will be considered acceptable for purposes of surcharge calculation.

Q: Where can I find the current surcharge rates for hospitals?

A: Please refer to the most current Bulletin issued by the Commissioner under Insurance Laws & Bulletins section of the IDOI website.

Q: Can entities affiliated with a hospital share in the hospital limits?

A: Only the entities listed on the Department of Health license application can share in limits of the hospital. If an entity is not listed it must obtain its own limits of $250,000/$750,000 unless the entity listed is strictly a d/b/a of the hospital and not a legal entity registered with the Indiana Secretary of State's Office. Following are steps that can be taken to make this determination:

Check to see how the facility/entity is licensed using the following websites:

Indiana Department of Health:

http://www.in.gov/isdh/reports/QAMIS/acc/hospital/index.htm

Indiana Professional Licensing Agency:

https://extranet.in.gov/WebLookup/Search.aspx

Indiana Secretary of State:

https://secure.in.gov/sos/bus_service/online_corps/name_search.aspx

If licensed as a hospital proceed to check the following website to determine all facilities listed on the hospital license application with the Indiana Department of Health to determine which locations may share in the limits of hospital:

http://www.in.gov/isdh/reports/QAMIS/acc/hosrpt/search.htm

If the entity is not listed on the hospital application with the Indiana Department of Health or does not hold a license as a hospital, the entity must obtain separate limits; therefore, conduct a search of the Indiana Professional Licensing Agency first and then the Secretary of State to determine how the entity is licensed/authorized.

* IF THE ENTITY IS NOT LISTED ON ANY OF THE ABOVE WEBSITES. Then determine whether the name given is a d/b/a of the hospital/entity. If so, the name must be reported to the PCF for coverage to be afforded to the d/b/a in accordance with IAC 760 1-21-10.

Indiana PCF Submission: Must be submitted as an ISO code 80999 if the entity does not hold a hospital or nursing home license.

Indiana PCF Submission: Must be submitted as an ISO code 90000 (hospital) and 80923 (nursing home).

Q: If a health facility "employs" someone with a Professional Employer Organization (PEO), can that person be covered by the health facility's professional liability coverage and the PCF?

A: In 2005 Indiana passed a statute addressing PEOs in general (IC 27-16). Pursuant to IC 27-16-2-5, the person is co-employed by the client (health facility) and the PEO. Under IC 27-16-7-4, the client (health facility) is responsible for the professional acts of the co-employee. However, this responsibility can be altered by specific contract language (IC 27-16-7-2).

The individual who is co-employed can be covered by the facility's professional liability coverage and PCF, but a statement must accompany the certificate of insurance filed with PCF stating the entity's proof of financial responsibility includes coverage for individuals that are co-employed with a PEO.

Q: Can individuals who are classified as residents or fellows share in hospitals limits even though they do not fall within the definition of "Employed Physician" found in 760 IAC 1-21-2(6)?

A: Yes. Because of the unique nature of the relationship between institutions, such as universities and hospitals, and residents and fellows, the Department will allow residents and fellows to share the institution's limits with regard to activities associated with the residency or fellowship. We intend to write this exception into Rule 21 when it is next amended. However, to share in the institution's limits fellows must participate in a full-time fellowship with no additional practice, except for part-time "moonlighting" work.

Residents and fellows should check with the institution to determine the institution's practice and protocols regarding professional liability insurance for residents and fellows.

Nursing Homes

Q: How is surcharge calculated for nursing homes?

A: Nursing homes pay a per bed rate as set out under IAC 760 1-21-8.5. The nursing home calculation sheet that is to accompany the filing to the PCF is available under the Companies or Entities section under Medical Malpractice in Excel format.

Q: What ISO Code is utilized when qualifying a nursing home with the PCF?

A: 80923

Physicians

Q: How is surcharge calculated for physicians?

A: First determine the physician's class , which is based on the physician's specialty. Physician specialty codes are found under IAC 760 1-60-3. Once this is determined, refer to the appropriate bulletin issued by the Commissioner setting out the annual surcharge per class**.**

Q: Can providers with individual limits take multiple credits and is there a limit on such credits?

A: Multiple credits (discounts) are NOT allowed. The insurer may apply only the greatest credit applicable.

Q: How is a "newly licensed" physician calculated in relation to credits?

A: Newly licensed physicians will get credits for the first two years of practice (the first two policy years). These credits do not apply to a physician who went back to school and changed specialties or who moved to Indiana after practicing in another state.

Q: What about a physician who has more than one specialty?

A: If a physician is practicing two different specialties, the exposure to the PCF is such that the surcharge rate paid should be the higher of the two.

Q: Is part-time rating applicable to the number of hours worked in Indiana only?

A: Yes, Indiana only.

Q: When can the medical school faculty credit be applied?

A: The Medical School Faculty credit of 67% can only be applied if the physician is engaged in research or teaching at a medical school as defined in IC 25-22.5-1-1.1(h). To be eligible for the credit, no more than thirty percent (30%) of the physician's time may be spent treating patients whose treatment is unrelated to the physician's duties at the medical school.

Q: How is surcharge calculated for a provider who holds multiple policies?

A: The agent/insurance carrier for the second policy would have to determine how the provider is currently qualified with the PCF. If the second policy that is being reported for proof of financial responsibility is at a lower classification, then the minimum $100 surcharge should be paid. A certificate should be submitted reflecting that fact in top right hand corner. If the second

policy is at a higher classification than the first, then the difference between the higher classification surcharge and the lower classification surcharge needs to be remitted, and the difference reflected in the surcharge amount field on the certificate along with the same explanation as indicated above.

ER Groups/Physician Owned Facilities

Q: How will emergency room groups and physician-owned facilities be rated?

A: Physicians will need to pay the surcharge for their appropriate class, with any allowable credits. This must be done separate from facilities or practices which they may own, in whole or in part. Facilities which are not specifically licensed as a nursing home or hospital will pay surcharge at a rate of 110% of the underlying premium.

Q: Can physicians who are employed by ER Groups/Physician Owned Facilities share in the limits of group or facility?

A: No, as per IAC 760 1-21-10(c).

Certificate of Insurance Filings

Q: How does an insurer handle return of surcharge issues?

A: Insurers that return premium due to cancellation or other reason should also return the applicable surcharge. Credit should then be taken by the insurer against the monies owed by the insurer in its next filing with the PCF. Under IC 34-18-5-2(e), the Patient's Compensation Fund is to collect $100 as a minimum surcharge, even if a provider's surcharge calculation results in a lesser amount. Minimum surcharge should always be considered "earned" for purposes of refunds or return of surcharge. Except for extraordinary circumstances, the PCF **does not** issue refunds of surcharge.

Q: How do insurance carriers and/or brokers report the credit being taken on future filings?

A: When making a filing utilizing a credit, the insurance carrier and/or broker should document in a cover letter the amount of credit being utilized and what amount of credit remains if any. If the credit amount being taken or remaining does not agree with Department records, the insurance carrier and/or broker will be contacted to discuss any discrepancies.

Q: Are electronic signatures acceptable on the certificates of insurance?

A: Electronic signatures are not acceptable at this time.

Q: When are surcharges due to the PCF, and what penalties are assessed for untimely filing?

A: Please refer to Bulletin 147.

Q: Does an insurance carrier have to go through an approval process to submit certificates to the Fund?

A: The only requirement is that the insurance carrier must be admitted or authorized to conduct business in Indiana. You may review a listing of these carriers on the IDOI website under the Company/Entity section.

Q: Who is responsible for making the filings to the PCF if coverage is written through an authorized surplus lines carrier?

A: Certificates and surcharge payment must be remitted by a licensed Indiana surplus lines producer.

Q: If coverage is issued through an authorized surplus lines carrier is the agent required to remit tax on the surcharge amount due?

A: The surcharge is not monies owed to the carrier, therefore no tax is due.

Limits of Liability

Q: What limits must an individual provider/facility carry when participating in the Indiana Patient's Compensation Fund (PCF)?

A: Individuals $250,000/$750,000
Hospital less than 100 occupied beds $250,000/$5,000,000
Hospital 100 or more occupied beds $250,000/$7,500,000
Nursing Homes less than 100 licensed beds $250,000/$750,000
Nursing Homes 100 or more licensed beds $250,000/$1,250,000
HMOs (Managed Care) $250,000/$1,750,000

Q: What if a provider carries higher limits and participates in the PCF?

A: Limits of liability for the Indiana exposure are those stated under IC 34-18-4-1. It's the Department's position that if higher limits are maintained those limits must be tendered before a claimant would be eligible to receive excess damages from the PCF, and the health care provider would not receive the full benefit of the excess coverage.

Q: Do nursing homes owned by the same entity have to maintain separate limits?

A: Yes, if each of the facilities are separately licensed through the Department of Health then separate limits must be maintained. This can be determined from the IDOH website.

Q: Can entities/locations that are owned by the same parent share in the limits of the parent corporation?

A: It depends on how the entities are registered with the Indiana Secretary of State's office. If each entity/location is a separate legal entity, then each one will need to maintain separate limits of liability and qualify separately under the PCF. If the entity/location is registered as an assumed name under the parent, then the entity/location may share in limits of the parent corporation.

Participation

Q: Who can participate in the Indiana Patient's Compensation Fund?

A: Any entity and/or individual as defined by IC 34-18-2-14 may participate in the Indiana Patient's Compensation Fund. Any member of the medical field that is not specifically listed under Indiana Code 34-18-2-14 may not participate on an individual basis, but would need to qualify through the entity which employs the health care provider in accordance with IC 34-18-2-14.

Q: How does an individual/entity become a participant in the PCF?

A: The health care provider must first purchase the appropriate underlying limits from an insurance carrier admitted or authorized to conduct business in Indiana. Once this is accomplished, the insurance carrier/broker would determine the amount owed and collect the surcharge from the provider. The PCF does not interact directly with providers; therefore, all filings are made by the insurance carrier/broker.

Q: Can an out of state entity become qualified provider under the Indiana Medical Malpractice Act?

A: Yes, as long as the entity falls within the definition of health care provider as per IC 34-18-2-14(7).

Self-Insured

Q: Can a hospital be self-insured and still become a qualified provider under the Indiana Medical Malpractice Act?

A: Yes, please refer the filing requirements on the IDOI website. Instructions for self-insured hospital filing.

Statute Changes

Is the Department required to send any type of notification to the insurance carriers regarding changes to the statute, rules, bulletins etc.?

No, but the Department does maintain a listing of interested parties who wish to receive notifications of changes. If you would like to have your name added to the listing, please email agunter@idoi.IN.gov. All statute changes are posted on the Department's website at www.in.gov/idoi under "Insurance Laws & Bulletins".

Locum Tenens

Q: How are filings made for a locum tenen physician?

A: There are two ways a filing can be made. First, a physician can purchase coverage for a year and take the applicable credits; or second, a certificate could be filed for each assignment the physician is working. Please keep in mind that if a certificate is filed for each assignment and underlying coverage is claims-made, the PCF requires that a reporting endorsement accompany the assignment certificate.

Q: How is surcharge calculated for locum tenen physicians?

A: The Department has developed a locum tenen worksheet to assist in calculating the surcharge. A copy of the locum tenen worksheet must accompany the filing.

Reserve/Claim Notices

Q: Does an insurance carrier/self-insured hospital have to file notice of claim against health care provider if a proposed complaint has not been filed with the Department?

A: Yes, per IC 34-18-9-2, a medical liability insurer of a health care provider against whom an action has been filed under IC 34-18-8-6(a) shall provide written notice to the Commissioner within thirty (30) days after filing of the action, and upon final disposition of the action.

Q: How and when are reserve notifications filed?

A: An insurance carrier/self-insured hospital setting a reserve must make the appropriate filing as per IC 34-18-9-3(a) and Bulletin 119. Reserve notifications should be sent to:

Indiana Department of Insurance
Medical Malpractice Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204-2787

Q: How and when are settlement notifications filed?

A: A health care provider's insurer or risk manager must file a settlement notification within sixty days after the final disposition, and it should include the information listed in IC 34-18-9-3(b). Please note that if settlement notifications are not filed, the Department's file remains open whether a settlement was or was not paid.

National Practitioner Data Bank (NPDB)

Q: Why is the Patient's Compensation Fund reporting a payment in my name?

A: A payment made by the PCF to a plaintiff is made on behalf of every healthcare provider who participates in a settlement which allows the plaintiff access to the PCF. Under federal law, the PCF is required to report medical malpractice payments, made on behalf of physicians, to the NPDB.

Q: What if I want to dispute the report?

A: The copy of the report that you received from the NPDB includes a notice of how to file a dispute. Follow those instructions. If you do not have the report sent to you by the NPDB, go to http://www.npdb-hipdb.com and obtain a *Subject Statement and Dispute Initiation* form.

Q: How will people know that multiple reports to the NPDB only involve one claim of malpractice?

A: You are allowed to submit comments to the NPDB. Instructions on how to do so are included in the report that you received from the NPDB.

Q: My insurance company only paid a fraction of the settlement with the plaintiff, and other healthcare providers paid the rest. How does the Patient's Compensation Fund decide how much to report on behalf of each healthcare provider?

A: The Patient's Compensation Fund reports payments to the NPDB in the same proportion that each healthcare provider participated in the *present value* of the settlement with the plaintiff.

> Example: A physician and a hospital participated in a settlement with a plaintiff which will eventually pay the plaintiff $100,000. The present value of the payments made is $75,001. The hospital made a cash payment of $25,000 (1/3 of the $75,001), and the physician paid $50,001 (2/3 of the $75,001). The Patient's Compensation Fund paid $300,000 in excess damages. The report to the NPDB would show a payment of $200,000 on behalf of the physician (2/3 of the $300,000). The Patient's Compensation Fund would not report a payment on behalf of the hospital if the payment was made solely for the benefit of the hospital. If, however, the payment is made by the hospital on behalf of a second physician, the PCF would report $100,000 (1/3 of the $300,000) on behalf of the second physician.

Q: Why wasn't I consulted as to the amount of payment from the Patient's Compensation Fund?

A: Under the Indiana Medical Malpractice Act, you have a right to object to payment demanded by a plaintiff within twenty days after you are served with a copy of the summons and plaintiff's petition for excess damages. If you think that you weren't served properly, you should contact your attorney. If a healthcare provider does not file an objection, the PCF proceeds with litigation of the claim independently.

Q: Where can I find more information about the NPDB and its requirements?

A: The NPDB web site is http://www.npdb-hipdb.com. The *NPDB Guidebook* is available in PDF form under the heading "Publications" on the NPDB web site.

D/B/A's

Q: Do d/b/a's have to be reported on the health care provider's certificate of insurance filed with the PCF to be afforded coverage?

A: Yes, as per IAC 760 1-21-10-(b). Any separate legal entity must have independent coverage.

Q: Can a d/b/a be reported under an individual physician's certificate?

A: Yes, as long as the d/b/a is not incorporated thereby being a separate legal entity.

Q: Can d/b/a's be reported under a hospital if not listed as a facility operating under the hospital license as indicated under IAC 760 1-21-10(a)?

A: Please refer to the Hospital section of the FAQs.

Q: Do d/b/a's have to be registered with the Indiana Secretary of State to be reported on the health care provider's certificate filing with PCF?

A: No

Q: Is surcharge due when adding d/b/a's to a health care providers filing?

A: Please refer to IAC 760 1-21-10(b)

Q: Is the $100 minimum owed for each d/b/a added to the health care providers filing?

A: No, $100 is owed for each certificate filing adding d/b/a's.

Q: When is additional surcharge owed per IAC 760 1-21-10(b) for adding d/b/a's?

A: Additional amount is owed if filing is made after the initial or renewal filing is made with the PCF to qualify the health care provider, which did not include the d/b/a's.

Q: Is it necessary that an assumed business name be registered with the IN Secretary of State in order to be recognized as a qualified health care provider and thus gain compliance with the Act when named on the policy & filing?

A: The purpose of the change to Rule 21 was to allow businesses who may go by an alias that is not organized or registered under Indiana law (and doesn't need to be) to avoid lengthy, unnecessary litigation by a claimant eager to avoid the limitations of the Medical Malpractice Act. For example, John Smith, M.D., has a sign on the door that says "Smith's Medical Clinic." But Dr. Smith is a sole proprietor who doesn't have a corporation. Then Smith's Medical Clinic would be appropriately added as a d/b/a on Dr. Smith's Certificate of Insurance.

If Smith's Medical Clinic is registered as a corporation with the Secretary of State, then it needs to qualify with the PCF separately from Dr. Smith.